

REINTEGRATION AND AFTERCARE PLAN

Juvenile Name: _____

Date: _____

Date of Transfer/Release: _____

Residence upon release/transfer:

- ☐ Release to home with: ☐ Parent(s) ☐ Guardian(s)
☐ Transfer to home with services (specify):
☐ Transfer to transition facility (specify):
☐ Transfer to Independent Living program (specify):
☐ Release/Transfer to Foster Care:
☐ Release/Transfer to Other:

Parent/Guardian Name: _____

Release Address: _____

Family: (Family needs, rules, who is involved, boundaries, structure, etc.)

- ____ Parenting Class:
____ Functional Family Therapy (FFT):
____ Family Counseling (Other than FFT):
____ Reintegration Specialist (RS) Services:
☐ Other:

Medical/Mental Health:

- ____ Juvenile is classified as SED (if yes, check all that apply)
 ☐ Parents have been referred to Idaho Federation of Families
 ☐ Juvenile has been referred to Health & Welfare CMH Services
 ☐ Juvenile has been referred to CMH Council Wraparound Services
____ Referred for other mental health treatment (specify):
____ If 18 yo and over, referred to Adult Mental Health, if applicable:
____ Current psychotropic medications:
____ Parent has made follow-up appointment/s with psychiatrist/doctor for continuing juvenile's Medications. Date of appt: _____ Doctor's name: _____
____ Nursing has been notified and arranged for 30-day med supply:
____ Medicaid application completed. Date:
☐ Other:

Drug and Alcohol Aftercare:

- ☐ Outpatient D&A Treatment:
- ☐ Intensive Outpatient D&A Treatment:
- ☐ Local 12-Step Self-Help Meeting information given to Juvenile:
- ☐ Urinalysis:
- ☐ Other:

Other Counseling:

- ☐ Individual counseling
- ☐ Out-patient sex offender counseling:
- ☐ Other:

Social/Religious/Recreation

- ☐ Referred to Religious resources if desired
Name of community contact person:
- ☐ Recreational interest/resources identified:
- ☐ Other:

Community Education/Vocational Plan:

- ☐ Vocational Rehabilitation referral sent:
- ☐ Job Corp referral sent:
- ☐ School reintegration meeting held: Date

Name of school:

Contact persons:

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- ☐ Other:

Victim Restoration

Restitution Owed:

Restitution Paid:

Community Services performed:

Activity

Hours

Victim mediation:

Victim panel participation:

Other:

Probation/Legal/Gang Issues:

- ☐ Courtesy supervision Chief JPO contacted, if applicable
- ☐ Courtesy supervision JPO assigned, if applicable- Name:
- ☐ If Aftercare includes Interstate issues, IDJC Deputy Compact Administrator contacted (208) 334-5100 x122:
- ☐ Adult PO, if district court commitment- Name:
- ☐ Sex Offender Registry:
- ☐ Urinalysis Assessments required:
- ☐ Post release hearing date: _____
- ☐ Approved associations (*people, organizations*):
- ☐ Unapproved associations (*people, organizations*):
- ☐ Other:

RELAPSE PREVENTION PLANNING

- ☐ Relapse Prevention plan completed:
- ☐ Safety plan completed (if applicable):

Juvenile Services Coordinator Signature/Date
Idaho Dept. of Juvenile Corrections

Juvenile Signature/Date